KEWEENAW BAY INDIAN COMMUNITY

COMMUNITY ASSISTANCE PROGRAMS (C.A.P.)
16429 Beartown Road, Baraga, MI 49908
Telephone: (906) 353-8137 or (906) 353-6623 x4162
Fax: (906) 353-4141

UPDATE: Applications **WILL NOT** be accepted if your KBIC Tribal Id and all of those KBIC members living in your household do not match your physical address on your application. The Enrollment office is the Tribe's central contact office. You are required to update your Id and address with Enrollment before applying for **ANY** of the programs in the CAP office.

FY2014 CAP HOUSEHOLD APPLICATION

HEAD of HOUSEHOLD:

Last Name	First	Middle	Maiden	DOB	Name of Tribe	Tribal Id No.

SPOUSE:

Last Name	First	Middle	Maiden	DOB	Name of Tribe	Tribal Id No.

CONTACT INFORMATION:

Mailing Address	City	State	Zip	
Physical Address	City	State	Zip	County of Residence

Telephone Number	Cell Phone Number	Message Number (Telephone/Cell)

Additional Household Members

Last Name	First Name	Middle Name	DOB	Name of Tribe	Tribal Id No.

Is anyone temporarily absent from home (e.g. college, military service, etc.)? [ ] Yes [ ] No
Name of absent person? _____ Reason for absence? _____ Return Date? _____

PLEASE CHECK EACH OF THE FOLLOWING:

[ ] I certify that all of the information in this application is true, accurate, and complete to the best of my knowledge. I understand that giving falseor incomplete information may result in a referral to the prosecutor for fraud, and/or recovery of any funds paid out on behalf of me, my household, or a minor in my care.

[ ] I understand that failure to submit a completed application and all of its required documents will be considered incomplete and a determination of funding benefits will not be made on the request until all documents are received and application is filled in completely.

[ ] A decision will be made on my application within 10 working days of my initial application request date.

[ ] I understand that I have a right to file an appeal for denials and decisions not made in a timely manner. Hearings-Appeals procedure sheets can be obtained in the CAP office.

[ ] I hereby authorize the Release of Information on myself or any other member in my household, in order to obtain information specific to this application and related requests.

[ ] I have updated Tribal Ids with the Enrollment office for myself and ALL of the KBIC members living in my household.

CHECKLIST (Check off each item that you have provided):

[ ] Current Tribal Ids for each member in the household including applicant.

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Head of Household/Applicant *Signature* **Initial Request Date**

FY2014 CNAP Medical Travel Assistance

Date of Request:_____

Advance or Reimbursement (Circle One)

Name of HEAD OF HOUSEHOLD & KBIC Tribal Id:_____

Name of Requestor & KBIC Tribal Id: _____

Relationship to Patient: _____

Name of Patient & KBIC Tribal Id: _____

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Reason for Travel *(e.g. Medical, Surgery, Eyes, Dental, Psychiatric, etc.)*: _____

Requested Travel Date(s): _____ through _____

Duration: How Many Days: _____
How Many Nights: _____

Name of Specialist/Hospital/Institution: _____

City/Twnshp./Vlg. of Specialist/Hospital/Institution: _____

Is a driver needed or required for the Patient? [ ] Yes [ ] No
If yes, explain: _____

NOTES (Briefly explain situation): _____

_____

_____

_____

CHECK LIST:

[ ] Completed HOUSEHOLD CAP APPLICATION and its Required Documentation
[ ] Medical Specialist Appointment Verification
[ ] REFERRAL from Regular Physician to see Specialist or a Document of Proof that a Physician's Referral is Not Necessary for Treatment and/or Other Circumstance Requiring Specialist Care
[ ] Inpatient Hospitalization *(Admittance/Discharge/Documentation Indicating Length/Estimated Length of Stay)*

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HOTEL RECEIPTS *for travel advances* **MUST** *be submitted within 15 days from return of travel. Failure to do so, may result in denial of any future advances and only reimbursements will be made for the remainder of the fiscal year or the amount owed will be deducted from a future request.*

_____ _____

Requestor/Applicant's *Signature* **Date**